FAMILY FOOT HEALTH CENTER P.C.

THE HEEL PAIN CENTER

Podiatric Medicine & Surgery

Dr. Richard L. Lesser • Dr. Affan Akhtar

WELCOME TO OUR OFFICE

Today's Date:

Last Name	First	Middle Initial	Birthdate	Age

Spouses Name, Parent's or Guardian's Name, if a Minor	Birth Date	Patient's Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced

Residence Address	City	State	Zip

Home Phone Number	Cell Phone Number	Social Security Number	How were you referred?

Name of Employer	Occupation	Business Telephone

Name, Address and Telephone of Contact In Case of Emergency	Relationship

If Other Than Patient, Name and Address of Person Responsible For This Account

Do You Have Medical Insurance? Yes ❑ No ❑	Carrier Name	Subscriber Name	Subscriber Birth Date	Policy Number	Group Number

Is It Through Your Employer Yes ❑ No ❑	Is There Secondary Insurance Yes ❑ No ❑	Carrier Name	Subscriber Name	Subscriber Birth Date	Policy Number

Name Of Family Physician	Address	Date Last Seen	May We Contact Your Physician For Your Health Records? Yes ❑ No ❑

Have You Had Previous Treatment By a Podiatrist? Yes ❑ No ❑	When:	For What:

Social History: Do You Smoke? Yes ❑ No ❑ Do You Drink Alcohol? Yes ❑ No ❑	Family History: Arthritis ❑ Cancer ❑ Diabetes ❑ Gout ❑ Heart ❑ High Blood Pressure ❑ Sickle Cell Anemia ❑ Stroke ❑

Hospitalizations & Operations

My Main Foot and Ankle Problem Is:

This Condition Has Existed For:	Height	Weight	Shoe Size	Shoe Style

Please list all medications that you take:

Do You Have or Have You Had The Following: (DNK Means "Do Not Know")

	Yes	No	DNK
Anemia	❑	❑	❑
Gout	❑	❑	❑
Diabetes	❑	❑	❑
Arthritis/Bursitis	❑	❑	❑
Hepatitis	❑	❑	❑
AIDS/HIV	❑	❑	❑
Ulcer/Colitis	❑	❑	❑
Neurological Problems	❑	❑	❑
Emotional Problems	❑	❑	❑
Psychiatric Care	❑	❑	❑
Venereal Disease	❑	❑	❑
Presentaly Pregnant	❑	❑	❑
Thyroid	❑	❑	❑
Tuberculosis	❑	❑	❑
Epilepsy	❑	❑	❑
Liver Disease	❑	❑	❑
Kidney Disease	❑	❑	❑

	Yes	No	DNK
Rheumatic Fever	❑	❑	❑
High Blood Pressure	❑	❑	❑
Heart Trouble	❑	❑	❑
Stroke	❑	❑	❑
Asthma/Emphysema	❑	❑	❑
Eye Disorders	❑	❑	❑
Prone to Scarring	❑	❑	❑
Fainting Spells	❑	❑	❑
Excessive Bleeding	❑	❑	❑
Blood Disease	❑	❑	❑
Circulation Problems	❑	❑	❑
Varicose Veins	❑	❑	❑
Phlebitis/Blood Clots	❑	❑	❑
Cancer	❑	❑	❑
Prone to Infection	❑	❑	❑
Back Problems	❑	❑	❑

Are You Allergic to, or Sensitive to:

	Yes	No	DNK
Novocain	❑	❑	❑
Anesthetics	❑	❑	❑
Adhesive Tape	❑	❑	❑
Materials	❑	❑	❑
Foods	❑	❑	❑
Drugs	❑	❑	❑

Please list any allergies:

Please list any other medical conditions:

I Hereby Give Dr. Lesser Permission To Examine And Treat My Feet

Date: ______________________

Patient's, Parent's or Guardian's Signature: ______________________